Discourses of Helping Professions

Pragmatics & Beyond New Series (P&BNS)

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Volume 252

Discourses of Helping Professions
Edited by Eva-Maria Graf, Marlene Sator and Thomas Spranz-Fogasy

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Edited by

Eva-Maria Graf
Klagenfurt University

Marlene Sator
Gesundheit Österreich GmbH

Thomas Spranz-Fogasy
IDS Mannheim

John Benjamins Publishing Company
Amsterdam / Philadelphia

Library of Congress Cataloging-in-Publication Data

Discourses of helping professions / Edited by Eva-Maria Graf, Marlene Sator and Thomas Spranz-Fogasy.
p. cm. (Pragmatics & Beyond New Series, ISSN 0922-842X ; v. 252)
Includes bibliographical references and index.
1. Discourse analysis--Social aspects. 2. Professions--Terminology. 3. Social service--Terminology. 4. Sublanguage. I. Graf, Eva-Maria, editor. II. Sator, Marlene. III. Spranz-Fogasy, Thomas.
P305.19.P76D57 2014
158.301'41--dc23 2014026461
ISBN 978 90 272 5657 7 (Hb ; alk. paper)
ISBN 978 90 272 6943 0 (Eb)

John Benjamins Publishing Co. · P.O. Box 36224 · 1020 ME Amsterdam · The Netherlands
John Benjamins North America · P.O. Box 27519 · Philadelphia PA 19118-0519 · USA

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Discourses of helping professions

Concepts and contextualization

Eva-Maria Graf, Marlene Sator and Thomas Spranz-Fogasy

Discourses of helping professions unites contributions on prominent helping settings and interaction types and offers an overview of similarities and differences as regards interactive affordances and communicative tasks and the discursive practices applied for their solution within and across the various helping professions. Whereas traditional helping professions such as medical and psychotherapeutic communication are by now well-established objects of research in discourse and conversation analysis (see e.g. Byrne and Long 1976; Heritage and Maynard 2006; Spranz-Fogasy 2010; Sator and Spranz-Fogasy 2011 for doctor-patient interaction and Labov and Fanshel 1977; Peräkylä et al. (eds.) 2008; Pawelcyzk 2011 for psychotherapy), so-called developmental formats like supervision or executive coaching have only lately attracted linguistic attention (see Aksu in prep.; Graf et al. 2010; Graf 2012; Graf in prep.). Yet, research on both traditional and less traditional formats revolves around similar questions such as: What represents their endemic communicative core tasks and what is interactants' discursive repertoire to solve these? A closer look at the various professional practices thereby evinces a highly differentiated and complex picture of these helping professional formats with numerous sub-types, transitions and hybrid formats.

A helping profession is defined as a professional interaction between a helping expert and a client, initiated to nurture the growth of, or address the problems of a person's physical, psychological, intellectual or emotional constitution, including medicine, nursing, psychotherapy, psychological counseling, social work, education or coaching. To speak with Miller and Considine (2009: 405), helping professions deal with "the provision of *human* and *social services*". The helping profession is constituted in and through the particular verbal and non-verbal interaction that transpires between the participants. Interaction types, in turn, are (tentatively) defined here as bounded (parts of) conversations with an inherent structuring of opening, core interaction and closing section, in which participants solve complex communicative tasks. The specific interaction the participants

engage in thereby evinces the respective interaction type. To put it differently, the principal communicative task(s) define(s) the overall rationale of the (specific part of the) conversation, i.e. the interaction type. Interaction types are thus both located on the macro-level of interaction, when referring to entire conversations or interactions such as the anamnestic interview and on the meso-level of interaction, when referring to parts of conversations that center on clearly demarcated communicative tasks within the overall layout of the interaction (such as troubles telling in psychotherapy). Although closely related with, and at times hard to differentiate from, neighboring theoretical concepts such as 'activity type', we prefer 'interaction type' over 'activity type' in Levinson's (1992) and Sarangi's (2000) sense for its applicability on both the communicative macro and the meso-level.

Helping in and through communication as a means to solve an individual's problem has always been an endemic purpose of human communication and as such is inherent in its formats and characteristics: Especially the goal-orientation of communication, its overall purpose of solving tasks as well as the possibility to add another's perspective are central elements of helping professions (Kallmeyer 2001; Miller and Considine 2009) and thus experience a fundamental productivity in doctor-patient interaction, psychotherapy, counseling, coaching etc. These basal characteristics form the interactive baseline of helping professions. Socio-cultural and technological developments materialize in relatively recent professional formats such as coaching or telephone hotlines, while an ongoing specification and hybridization of communicative tasks like decision-making materialize in similar, yet format-specific, practices for their solution.

Communication is characterized by its constitutivity (i.e. communication is interactively constituted), interactivity (i.e. communication results from the intertwining and mutual coordination of participants' contributions and perspectives), processuality (i.e. communication evolves over time), pragmaticity (i.e. communication means interactively working on participants' shared and individual goals) as well as methodicity (i.e. applying socio-culturally shared practices for the communicative solution of common goals) (Deppermann 2008). Constitutivity transpires along a thematic-, identity- and relationship-dimension as well as an activity dimension (Kallmeyer 2005; see Sarangi 2000 for a related distribution into thematic, interactive, and structural dimension): Whereas participants co-construct a topic as 'primary concern', 'complaint' etc. on the thematic level, they co-construct their respective social roles and relationships as e.g. 'doctor-patient', 'therapist-client' etc. and finally, they apply and agree on particular activity formats to work on the primary concern, the complaint etc. In our post-modern world of increasing fragmentation, diversification and specialization of knowledge, the above mentioned implications and potentials of interaction result in a growing number of (communication) experts such as doctors, therapists, supervisors or

coaches and in growing affordances as regards their professionalization. Whereas helping interaction was originally understood to solve social and individual problems of a medical or psychological nature, it has become increasingly relevant for communication-intensive professions such as therapy, teaching etc., where counseling supervision helps professional communicators to reflect on their own professional communication with their clients. That is, helping professionals support other helping professionals in their respective communicative interaction with their clients, patients, customers. Another, more recent site of helping interaction is the larger organizational context of human resource development, where professional communicators support their clients in self-development and -reflection, optimizing managerial skills or eliciting peak performance for their own sake and the sake of the organization. The individual and his or her physical, psychological, emotional, professional or intellectual needs are thereby always embedded in some kind of institutional context. Besides communicative support on the individual level, the ongoing social differentiation and repartition of knowledge leads to a growing need for external professional support on the organizational level, too. However, the focus here is on helping interaction on the individual, not the organizational level as is found e.g. in management consulting (see e.g. Habscheid 2003).

Whereas the book's larger framework builds on the analogy between helping interaction and the basal characteristics of communication, the more specific framework zooms in on the similarities, differences and interferences within and across the various helping professional interaction types and their overall purpose of communicatively tackling a patient or a client's physical, psychological, emotional, professional or managerial concern.

The edited volume thereby adds the following two aspects to the analysis of professional interaction: Besides Sarangi and Roberts (eds.) (1999), it is the first discourse analytic book specifically dedicated to helping professions as its overarching thematic focus. Alongside research focusing on institutional discourse (see Drew and Heritage (eds.) 1992; Arminen 2005), professional discourse (see Gunnarson et al. 1997; Candlin (ed.) 2002), language and communication in organizations (see Candlin and Sarangi (eds.) 2011) or workplace discourse (see Koester 2010), and research with a specific helping professional focus such as language and health communication (Hamilton and Chou (eds.) 2014), it adds to our general understanding of helping professions and their particular communicative and interactive characteristics. Such insight is particularly relevant in sight of the omnipresence and socio-cultural importance of helping professions in late modern society as part of the expert-system in our therapeutic culture (Giddens 1991; Furedi 2004).

The second innovative aspect lies in the inter-professional perspective. Up to this point, various helping settings and interaction types have been analyzed

intra-professionally in their own right, i.e. within their respective professional boundaries (see e.g. Neises et al. 2005; Heritage and Maynard 2006; Nowak and Spranz-Fogasy 2009 for the medical context, Peräkylä 1995; Muntigl 2004 and Hutchby 2007 on various types of counseling and e.g. Labov and Fanshel 1977; Peräkylä et al. 2008 and Pawelcyzk 2011 for the therapeutic context). One strand of research has thereby focused on the internal diversity and gradual morphology of e.g. medical interaction or therapeutic interaction (see e.g. Ruusuvuori 2005 on the difference between homeopathic and GP consultations in the case of problem presentation). Yet, the recurrence of particular interaction types or discursive practices across different helping professions has not been at the center of discourse-analytic attention on a larger scale (for individual projects see e.g. Pawelczyk and Graf 2011 on stereotypical feminine strategies as agents of change in psychotherapy and coaching and Pick et al. (in prep.) on the interactive characteristics of initial sequences in legal consultation, supervision and executive coaching). Although the overlap and reappearance of particular discursive practices has been acknowledged for institutional and professional interaction in general (cf. Drew and Heritage 1992: 27; Sarangi 2004: 6), the possible sharing of interaction types as well as its local and global consequences has so far not been addressed in the context of helping professions. The attested fluctuation and recurrence of particular interaction types across helping professions must be interpreted as a product and consequence of the "plurality and fragmentation of late modern social life" (cf. Chouliaraki and Fairclough 1999: 5). This in itself is of linguistic and interactional nature as the processes of fragmentation and differentiation are constituted in a proliferation of language uses.

The purpose of the edited volume is to spark off a theoretical and conceptual discussion on variation and recurrence of communicative tasks and discursive practices in helping professions by focusing on their hybrid character as well as on the gamut of their discursive intra- and inter-variation. Authors from different linguistic, sociological, conversation analytic and helping professional practical backgrounds offer their expertise in medical, psychotherapeutic, supervision and coaching interaction. The contributions are united on the theoretical level by recurring thematic aspects such as empathy and feelings-talk, keeping clients on track in spite of their verbosity or resistance, professional identity and role construction. Another recurring topic is deviation from the professional agenda or other communicative disturbances, findings that offer valuable insight into interactants' underlying expectation as regards the particular activity format. On the structural level, the contributions are united by aspects such as the relevance of specific sequential positioning of participants' contribution. As regards data and research methods, all contributions work with authentic data from professional helping interactions (in Peter's contribution, the data stem from an authentic

medical training context). Yet, given that the studies were carried out individually in different contexts for different purposes, the data are analyzed with a variety of methods such as CA, applied CA, integrative qualitative analysis or discourse analysis. Due to the same fact, the data are transcribed following different conventions such as Jefferson, GAT2 or HIAT from (slightly) different theoretical backgrounds; these conventions are laid out in the respective references of the individual contributions.

Although the practical application of their findings in the various fields of helping professions is not the primary motivation of all contributions, already the more theoretical insight is of practical value: the increasing fragmentation and specification of the helping business results in a growing insecurity on the side of the patients, clients and consumers of helping professional services. A clearer picture of how and where interaction types in helping professions truly differ offers the necessary orientation for those in search of such services (see e.g. Graf and Pawelczyk (this volume) and their comparison of psychotherapy and executive coaching in their respective dealing with feelings-talk). Another relevant practical aspect is the training context of (future) helping professionals: discourse-analytic findings as regards the interactive specifics of their professional doing could and should be integrated in (future) trainings and the respective manuals for doctors, therapists, coaches, counselors etc. This is in accordance with Antaki's (2011) claim for using conversation analytic findings as forms of intervention and change in institutional talk and is particularly exemplified e.g. in the contributions by Sator and Graf or Menz and Plansky.

Contributions

In more detail, the contributions in *Discourses of Helping Professions* focus on the following discursive practices across helping professional communication:

The first chapter by **Antaki**, *How practitioners deal with their clients' "off-track" talk,* addresses professional practices of keeping clients on track from the above mentioned applied conversation analytic perspective: The popular expectation of helping professions is that the client's troubles and concerns take priority on the floor. On the other hand, professional staff may have other more pressing objectives and priorities. There is then a dilemma. For example, at some point in a psychotherapy session, the therapist may have a specific therapeutic or managerial objective in mind which is to be pursued closely, even at the expense of seeming to be unresponsive to the client's currently expressed concerns. What is a therapist to do when the client's talk is not – as the therapist judges – 'on track' with the therapeutic agenda? To the degree that psychotherapy texts address the question at all,

they may be firm in their recommendation that the therapist proceed sensitively. However, as Peräkylä and Vehviläinen (2003) observe about psychotherapy practice, textbooks are not helpful in giving detailed instruction in how therapeutic principles are actually to be embodied in the details of talk. Here, then, is a chance for a close, detailed reading, such as is offered by Conversation Analysis (CA), of the actual recorded practices of therapists and other helping professionals. Based on an inspection of sessions with intellectually impaired and non-impaired clients, seven conversational practices are identified by which staff may keep the session "on-track" in the face of possible deviation.

Muntigl, **Knight** and **Watkins**' contribution *Empathic practices in client-centred psychotherapy. Displaying understanding and affiliation with clients* explores how client-centred empathy is practiced within a specific interaction type: troubles telling sequences. Building on the work of Carl Rogers, who viewed empathy as a form of understanding that privileges the client's point of view, empathy is examined as an interactional achievement in which clients create empathic opportunities by displaying their affectual stance, followed by therapists taking up these opportunities through affiliative displays. It is found that empathic practices could be realized through a variety of verbal (naming other's feelings, formulations, co-completions) and non-verbal resources (nodding, smiling). Further, the data evinced that continuers played an important role in helping clients to develop their troubles stance in more detail, which, in turn, invited more explicit empathic displays from therapists.

Empathic practices and feelings-talk are also at the centre of the contribution by **Graf** and **Pawelczyk** *The interactional accomplishment of feelings-talk in psychotherapy and executive coaching – same format, different functions?* looks into the forms and functions of feelings-talk in two important 'helping' contexts, i.e., psychotherapy and executive coaching. In psychotherapy, the therapist's elicitation of clients' experiences of stressful and traumatic events fulfills important functions such as facilitating clients' new appraisals of the stressful situations. In this sense a psychotherapeutic interaction emerges as a model of performing emotional labor offering multiple modes of communicating emotional experience. As one consequence of the therapeutic culture of late modern society feelings-talk has also entered the managerial realm. Despite the entrepreneurial and business-oriented character of executive coaching, clients' verbalizations of emotional experience constitute a central element in coaching interaction. By applying an integrative qualitative analysis, **Graf** and **Pawelczyk** discuss the particular function of feelings-talk in the two different professional formats and illustrate how this endemic communicative task of therapeutic interaction is adapted to meet managerial affordances in the context of executive coaching.

The next chapter by **Sator** and **Graf** is also dedicated to the relatively recent and under-researched helping profession 'coaching'. In "*Making one's path while walking with a clear head*" – *(Re-)Constructing clients' knowledge in the discourse of coaching: Aligning and dis-aligning forms of clients' participation*, the authors focus on the communicative task of (re-)constructing clients' knowledge. Knowledge (re-)constructions represent an endemic interactive feature of this helping profession, which aims to solving clients' business-related concerns via developing concrete solutions for their problems. Besides its solution-orientation, coaching is guided by the professional norm of enabling help for self-help. This action-guiding assumption locates all relevant information in clients' territory of knowledge and disapproves of strongly directive interventions such as interrupting the client. A dilemma may arise for the professional when clients non-align in constructing a solution given that concrete plans of actions are required, but should be developed co-actively based on clients' own knowledge. The chapter tackles the interactive consequences of such dis-aligning forms across one coaching session between an apprentice coach and his client by illustrating the coach's strategies in struggling with his professional dilemma and client's strategies to resist the professional's attempts to non-directively keeping her on track.

Form, function and particularities of discursive practices in one-on-one supervision in Germany by **Aksu** extracts discursive practices in supervision, another helping profession that has so far received little discourse analytic attention. One-on-one supervision in Germany is not always the counseling of a professional in the helping professions by a supervisor from a similar field. It can also be – due to its adaptation to modern work contexts – a counseling format for a professional in a managerial position, not unlike business coaching. In some cases, these two aspects converge. In her analysis, the author describes how two of the ubiquitous communicative tasks in one-on-one supervision ('establishing the need for counseling, establishing the counselor as authority' and 'presenting the problem') are tackled in light of this convergence and show that supervision is a conversation between experts who create a specific supervisor-supervisee relationship.

The next two chapters, *"I mean is that right?": Frame ambiguity and troublesome advice-seeking on a radio helpline* by **Hutchby** and *Professional roles in a medical telephone helpline* by **Landqvist**, tackle professional helping interaction that is not realized face-to-face, but mediated via radio and telephone, respectively. **Hutchby** analyzes the operation of the "expert system" for the provision of advice in the setting of a call-in radio program. He investigates the sequential properties of calls in which the central communicative activity of advice-seeking is merged with another activity, that of troubles-telling. In most calls, advice-seekers (members of the public) succeed in identifying a clear advice topic and advice-givers (the radio host and a social welfare expert) succeed in advising

on that topic, albeit within the distinctive constraints of the broadcast setting. In a small number of cases, however, there is a difference in that the advice-seeking turns instantiate an ambiguous framing in which it is unclear whether the caller is seeking advice about, or making a complaint about, the social welfare system. This poses a problem for the expert system comprising the show's host and accredited expert, in terms of how they design the reception of advice-giving turns and the development of subsequent sequences. The author shows how the different speaker identities of caller, host and expert operate in different ways as the expert system responds to the call's frame ambiguity and seeks to re-invoke the standard features of advice-giving.

Landqvist, in turn, addresses the professional roles of medical advisors working in a medical help line. The analysis focuses on calls about the swine flu epidemic in 2009 and analyzes role shifts of the advisors due to changing situations and callers' needs. This study is mainly instructed by the concept of hybridity as a main characteristic of counseling as an interaction type. Several sub-types, communication tasks such as expert-based problem solving and strategies such as social chatting and joking are identified, all of which are connected to the shifting contexts of call. Tasks and strategies used by the advisors are examined and described as relevant and to some degree typical subtypes in a modern medical help line. Phenomena like hybridity and role shifts are thus viewed as reflections of the context models used and as their updates, and as a necessary trait of an advisor's professional communicative competence.

The last group of four chapters is dedicated to the traditional helping profession 'doctor-patient interaction' and adds to our already extensive discourse analytic insight into how doctors and patients communicate with each other within and across medical schools, specializations and settings, by examining patients' anticipatory reactions in history taking, by zooming in on the doctor-patient relationship, by investigating into reasons for protractions in medical consultation and finally, by showing the hybrid communicative character of neurologists' making psychosocial attributions in the interaction with patients with functional neurological symptoms. In more detail, *Anticipatory Reactions – Patients' Answers to Doctors' Questions* by **Spranz-Fogasy** examines patients' answers to doctors' questions during history taking as a central activity format which reveal a deeper understanding of each other. An analysis of medical interactions shows that patients mostly expand the topical, structural and/or pragmatic scope of the doctors' questions. The sequential positioning of answers provides more possibilities than is to be seen from a strict perspective of question types. Patients' answers reflect their understanding of the current interaction type, and of the question's implications, doctors' relevancies as patients assume them, or even the doctors' presupposed next question; a phenomenon which is called anticipatory reaction. Both action

formats and their interplay point to two important principles of interaction: the principle of cooperation and the principle of progressivity within the frame of the particular interaction type.

Peters' contribution on *"Doctor vs. Patient" – Performing Medical Decision Making Via Communicative Negotiations* investigates into how the physician-patient-relationship is initially established in the context of medical decision making. While the relationship is of major concern in linguistics and medical ethics, the theoretical constructs on medical decision making hardly provide insights into how it is discursively constructed. The relationship is not fixed at the beginning of the initial conversation and is continuously negotiated between doctor and patient in the course of the interaction, based on their respective specific ideas and perceptions. The findings of videotaped interactions between medical students and standardized simulated patients indicate that the physician-patient-relationship can be explored in respect of at least three different aspects, namely (1) the conversation structure, (2) the content focus of the dialogue and (3), the process of decision making. A change in one of these aspects – initialized by both conversational partners in using the whole spectrum of multimodal communication – will influence the other ones. By use of different instruments of power in communication, physician and patient negotiate the type of their physician-patient-relationship and thereby determine the mode of decision making.

In *Time pressure and digressive speech patterns in doctor-patient consultations: Who is to blame?* **Menz** and **Plansky** ask who is responsible in protracting medical consultation: Medicine, among the oldest and institutionally best developed helping professions in Western societies, finds itself characterized by a number of unique aspects, among which is the increasing fragmentation of the medical sciences which in turn has resulted in the "fragmentation of the patient" (Mishler 1984). One of the most visible forms of fragmentation is the fragmentation of time in medical treatment represented by small time slots and long waits for the patients. In this respect public health service differs significantly from other types of helping professions as executive coaching, psychotherapy or supervision counseling. Physicians frequently blame verbose patients, who cannot easily be prevented from talking, for increasing scheduling problems. This contribution, however, will present some opposing results. On the basis of a quantitative and qualitative analysis of 268 transcribed medical interviews the findings indicate that it is not so much the patients' psychic structure ("being talkative") that protracts medical consultations, but rather the physicians' interactional patterns. For medical education (in particular, and counseling settings in general) these results might be of considerable interest as they counter popular prejudices on patient behavior and might contribute to reshaping the doctor-patient relationship.

The final chapter by **Monzoni** and **Reuber** on *Neurologists' approaches to making psychosocial attributions in patients with functional neurological symptoms* zooms in on neurologists' approaches to making psychosocial attributions in patients with functional neurological symptoms: Doctors perceive consultations with patients with functional neurological symptoms (FNS) as challenging because of the dichotomy between the psychosocial nature of the symptoms and patients' perceptions that their condition is essentially physical. Through conversation analysis, the authors describe some communicative strategies neurologists employ to make psychosocial attributions, ranging from unilateral to more bilateral approaches. In unilateral approaches doctors employ general explanations about the psychosocial aetiology, thereby pre-empting any potential resistance. In bilateral approaches, doctors actively involve patients in discussing potential psychosocial causes, by also making direct and specific psychosocial attributions. These practices display doctors' great caution in this communicative task; and they exhibit a hybridization with those employed by psychologists, which might be strictly linked to this type of patients.

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How practitioners deal with their clients' "off-track" talk

Charles Antaki

In institutional encounters where a client engages with a practitioner for advice or guidance, there is a phase in which the client may be expected to 'tell their tale' before the practitioner offers a response. In this chapter I shall analyse the kind of professional conversation which involves with a client being invited to describe a personal and indeed intimate problem, in order for the professional to offer their perspective (and possibly suggest a solution). The client's problems here are matters of emotion, conflict or life-style, caused or sharpened by psychological disorder or disability – in other words, we shall be listening in to what the editors term as the 'professional format' of the counselling, personal-support and therapy consultation.

1. Introduction

In institutional encounters where a client engages with a practitioner for advice or guidance, there is a phase in which the client may be expected to 'tell their tale' before the practitioner offers a response. That is the 'interaction type', as the editors of this volume usefully call it, that I shall concentrate on in this chapter. As the editors say, "interaction types … are … bounded (parts of) conversations with an inherent structuring of opening, core interaction and closing section, in which participants solve complex communicative tasks" (Graf, Sator and Spranz-Fogasy, this volume, p. 1). What I have in my sights is that kind of professional conversation which involves with a client being invited to describe a personal problem, in order for the professional to offer their perspective (and possibly suggest a solution). The client's problems here are matters of emotion, conflict or life-style, caused or sharpened by psychological disorder or disability – in other words, we shall be listening in to what the editors term as the 'professional format' of the counselling, personal-support and therapy consultation.

Common to all of these is the need for the practitioner to get their client to tell their troubles in some sort of narrative. The communicative task facing both parties is getting this narrative ' right' – tailoring its delivery (length, detail, content) to the needs of the conversation at that point. My interest is in what happens when that tailoring goes wrong, and the narrative is stopped or diverted by the practitioner, who has judged that the client has strayed too far from the agenda – that the client has gone "off-track". Dealing with such behaviour is a complex business, and, as we shall see, the practitioner needs to try and be firm while also being supportive.

How might a client go 'off-track'? In ritualised settings the troubles-telling stage of the proceedings is fixed and clear to both parties (for example, in a religious confessional, where the question-and answer format limits the penitent to a set time in which to recount her or his sins), and there are conventional or ritualised formats in which to deliver the trouble-description. But in more mundane interactions the boundaries are diffuse. This chapter is about what happens when the client's troubles tale is treated by the practitioner as having spilled over into an inappropriate part of the encounter – perhaps starting too soon, going on too long, or re-emerging after it had been apparently dealt with. I will be dealing with such policing of boundaries in two very different settings in the helping professions: sessions of psychotherapy, and interactions between support-staff and people with intellectual impairments. We shall see that the manner in which very different practitioners deal with the problem of 'off-track' talk (indeed, whether it *is* a problem) shares common conversational features, and becomes itself a constituent part of what the institutional service provides.

2. Ordinary practices for discouraging talk

An institution's ways of talking is only a variant of what happens in the primordial site of interaction, which is everyday conversation (which must necessarily have predated the development of institutions). And, in everyday conversation, there is a range of practices by which a person might treat another's talk as being off-track, or otherwise not to be encouraged. Both parties will have an eye to what Schegloff calls the *progressivity* of a speaker's actions in the turn they're currently constructing (Schegloff 1979) or in the sequence that they're building (Schegloff 2007); and at any point one participant may decide to encourage the other in their trajectory or, conversely, steer them away from the line they are taking. Encouragement is the norm, and Example 1 shows an example of encouragement in the arrowed lines.

Extract 1. (Rahman 1 4–6, notation greatly simplified)

```
01    G: And Danny didn't get in so I didn't get to typing
02       last night
03 →  L: Didn't [you
04    G:         [No I thought well I can't leave him for
05       two hours if I'm- if he's crying if I've left
06       him for one
07 →  L: Oh dear me
08    G: So er you know as I say I didn't get to typing
09 →  L: Oh you're well tied down aren't you
```

Speaker G is telling a tale about her son's crying preventing her from typing, and speaker L's contributions are all news receipts of an encouraging, go-ahead kind (see Heritage 1984 for the range), fitted to the newsworthiness of what is being announced, its emotional tone and showing, at line 9, an appreciation of its truth and aptness. Were the recipient of news less inclined to encourage the news-teller, they might steer them away from it gently or brusquely, forming a gradient of directness. In the case below, we are clearly towards the other end of the gradient, where D's silence speaks volumes:

Extract 2. (W:PC: I 1–3 notation greatly simplified)

```
01    S: Oh God we had the police round all night it was
02       hectic so I hardly got any work done
03 →     ((sound of horn beeping))
04    S: So consequently I didn't get any work done
05       hardly.
06 →     (0.6)
07    S: Anyway.
08 →     (2.0)
09    D: So- do you think- can you come out for a drink
10       tonight?
```

S is recounting a tale about not getting work done but, unlike speaker L in Extract 2 above, speaker D is not taking their opportunities at turn-transition points (arrowed) to express encouraging news-receipts. Indeed when D does take a turn (line 9), it is after a markedly long silence, and takes the form of a topic-changing invitation to come out for a drink. Invitations project agreement, or replies of some kind, so were S to try and re-establish the topic of their undone work, they would have to pay the cost of being as disaffiliative with D's new project as D was to theirs.

The gradient of discouragement from gentle to brusque is not one-dimensional. There will be many factors in play in deciding where to place your intervention,

and, in institutional settings, some of these will turn on the view that the practitioner has of the client, and of the client's interests vis-à-vis those of the institution. In the body of the chapter we shall see how those concerns play out differently in psychotherapy and in support for people with intellectual impairments.

3. Interactions in adult psychotherapy, and between residential support staff and adults with intellectual impairments[1]

The two kinds of interaction I shall report are quite different in terms of the clients' cognitive powers and their reasons for engaging with the practitioner. Nevertheless they share the feature of the practioner making space for the client to tell a trouble, and to then propose some assessment of it - or to manage the tale, if it strays outside what the practitioner considers to be its appropriate boundaries.

In talking about psychotherapy I shall concentrate on therapies which have a programmatic approach to their interactions with clients, where the transitions between troubles-telling and other phases of the interaction are more visible and more obviously policed. In Cognitive Behaviour Therapy, for example, therapists are meant to work to a clearly set-out schedule of activities within any one therapeutic session. Figure 1 is an example of a training manual's description of the phases that the therapist must go through.

Session structure and outline: early phase of treatment

1. Greet patient
2. Perform a symptom check.
3. Set agenda.
4. Review homework from previous session.
5. Conduct cognitive-behavior therapy (CBT) work on issues from agenda
6. Socialise to cognitive model. Teach basic CBT concepts and methods.
7. Develop new homework assignment.
8. Review key points, give and elicit feedback, and close session.

Figure 1. An example of a programme for a therapeutic session (from Wright et al. 2006: 78)

1. Part of the material in this chapter is based on data and analysis in Antaki and Jahoda (2010).

Even if the experienced CBT therapist does not stick fixedly to this brief, and even in other kinds of psychotherapy where there are less structured phases to go through, there will necessarily be times when the client's long rehearsal of their troubles would be inconsistent with the kind of activity cast, in CBT terms, as 'set agenda' (which more loosely would be something like 'agree with the client what would be done in that session') or 'develop new homework assignment' (perhaps 'make recommendations as to what the client might usefully do before the next session'). And if the client's talk does run, on, then there is a dilemma. The therapist will have a specific therapeutic or managerial objective in mind which is to be pursued, even at the expense of seeming to be unresponsive to the client's troubles-telling.

How is the practitioner to respond? Text-books (for example, Dryden 2007) are not unaware of such issues, but they lack detail in suggesting what the practitioner is to do. As Peräkylä and Vehviläinen (2003) observe about psychotherapy practice, textbooks may sometimes offer idealised examples but such idealisations can only get across what the author believes is the general 'feel' of an interaction, and may be wildly different from the specifics of actual talk. Conversation Analysis will help. As Peräkylä and Vehviläinen (2003) point out, a close analysis of recorded encounters will reveal significant and unsuspected detail in how therapists actually keep the client focussed.

With regard to the relationship between support-staff member and adult with an intellectual disability, the encounter is rarely so formally structured, yet there are many occasions in which staff an d client are engaged in some activity which provides for the staff member to ask the client to report on an event of concern or interest, either for purely informational reasons (the staff may need to know if there is anything wrong, or troubling the client) of out of an educational motive (the staff may need to test the client's understanding of such things as health practices). Her the exchange takes on the basic feature of interest to us: a space3 is provided for the client to report a concern, and that report may or may not 'fit' the boundaries allowed it by the practitioner.

Conversation Analysis (CA) is mostly applied to ordinary conversation, but has a developing interest in institutional encounters. Indeed, it has a long history of looking to see how therapy (and mental-health work in general) gets done in practice, beginning in the late 1960s with Harvey Sacks' account of an emergency psychiatric helpline and an adolescent group therapy session (both later published in his posthumous lectures; see Sacks 1992). There has now accumulated quite a body of CA or CA-inspired work in therapy. The collection edited by Peräkylä, Antaki, Vehviläinen and Leudar (2008) shows therapists' practices in initiating actions and in responding to what the client offers to the session. Contributors to that collection identify a number of practices that the therapist uses in

encouraging the client to talk, and to progress the session by offering formulations, reinterpretations, assessments and repairs of the client's words (and, by extension, the client's view of the events he or she was recounting).

In intellectual disability, Yearley and Brewer's (1989) pioneering work effectively established that people with all but the most severe intellectual disabilities were to be taken to have interactional, if not always linguistic, competence. Since then, CA-informed research has proceeded to fill out what we know about both voices in the dialogue: the practices of people with disabilities, and the practices of those around them – who often get, or take, a larger slice of the conversational cake. But the person with intellectual disabilities does not talk in a vacuum; Marlaire and Maynard's work (e.g. Maynard and Marlaire 1992) redirected people's attention off the client and onto the practitioner. They studied how the tester and testee collaborated in educational assessment sessions, and identified how the practitioner could induce the testee to act less competently than they would do in ordinary conversation, or in conversation less driven by institutional objectives. Their work, and subsequent work by researchers studying interactions in more natural settings (e.g. Williams 2010; Antaki, Finlay and Walton 2009), has made CA researchers more aware of the interplay between the practitioner's talk and that of the client, and allowed us to see their interdependence.

These two traditions of applied CA form a useful backdrop to the practices we have in our sights here: how a therapist, working with people with mental health issues, or a support staff member, working with adults with intellectual disabilities, may steer the client's talk in the direction that the institution requires.

4. Seven conversational practices to discourage the client's trajectory and keep the session institutionally "on track"

A given turn at talk opens up a space for a class of next action (thus a summons requires a response, a question requires an answer, a news report requires a news receipt, and so on – for a recent magisterial account of conversational sequences, see Schegloff 2007). When a client is making her or his report, that usually projects some sort of appreciation (a new receipt or an assessment). That keeps the interaction going on its trajectory, and the client is enabled to carry on. What we shall see, however, is that the practitioner can meet the client's words with a gradient of responses that, on the contrary, redirect, or try to redirect, the client's progress. The practitioner's redirections range from giving only *minimal receipts* of what the client has said, even when this would otherwise have warranted

expansion, all the way to explicit *active topic shift* which takes a more directive role. Such deviation is marked, and makes the talk go off on an alternative trajectory from the one that the previous speaker had indicated.

To prefigure what we shall see, the gradient is composed of the following practices, in ascending order of explicit direction (building on five practices identified in Antaki and Jahoda 2010):

- minimal receipt of newsworthy announcements
- non-request for clarification of confused narrative
- repeat of C's turn, or part of it
- formulation which closes the topic
- orientation to the need to keep on track
- non-engagement with client's talk
- explicit rejection of client's track

The practices are not exclusive, and we shall see how a practitioner may use a combination of practices, either across subsequent turns at talk or within one turn.

(1) The practitioner offers only a minimal receipt of announcements

When a person reports some event as an announcement, it can be met by a range of more or less encouraging receipts (Heritage 1984). Therapy sessions, certainly, are environments where clients are encouraged to announce their concerns, and they require at least acknowledgement by therapist (*active listening* is a phrase often used, in therapy texts, to describe appreciating the client's situation). Equally, a person with intellectual disabilities may well be asked to report on events in their day to day lives as part of what is called person-centred care. Again, such reports can be met more or less encouragingly. In all cases, the practitioner may judge that after a certain moment, the time is not right to encourage the client to elaborate on a given report. In the case of the CBT therapist for example, it would be unwelcome for the client to elaborate on their troubles in the in an agenda-setting phase, or in a homework review phase. In Extract 3 below, the therapist is making a list of things to cover in the session, and asks the client for clarification of how to word an item on hearing voices. In this, as in all the extracts used, any names that appear are pseudonyms, and any other identifying material has been removed or altered. "C" is the client, and "T" the therapist.

Extract 3. CBTM: SH/JR Session 1, min 16[2]

```
01   T: .hh okay, (.) so far we've got. (.3) no bedtime
02      routine, sleep, drinking a lot of water, worried
03      about epilepsy. (.) .hh <d'you wanna put the
04      voices down as a problem?>
05      (1.3)
06   T: or [no:t
07   C:    [erm:::
08   T: or is it shouting at the voices that's the problem.
09      (1.6)
10   C: (w- er- I- er-)=sometimes ah- I (.3) I scream very
11      loudly
12      (.6)
13   C: ts a bit of a problem (.) >bcs=sometimes,< I
14      scream s'loudly ahm=ma gla- ma ears hurt.
15 → T: so=sh'll we (.) put problems= [screaming loud at
16   C:                              [scree-
17   T: the voices.
18      (.3)
19   C: yeah.
20   T: good one.
```

In the extract above, the client's announcement *sometimes I scream very loudly* receives no acknowledgement from the therapist. The client then upgrades the report to *sometimes I scream so loudly my ears hurt*. Such 'news announcements' (Heritage 1984) strongly project explicit new-receipt by the listener (for example: *really? do they? oh?* among the more encouraging ones; see Heritage 1984). But the therapist gives no assessment or receipt whatever, instead meeting the announcement with a proposal of how to record the client's experience (the arrowed line 15), in line with the current business of the session, which is setting the day's agenda.

(2) The practitioner does not request clarification, even for unclear narrative

In both sets of interactions, clients' accounts may be difficult to follow, for various reasons; in some cases it is due to cognitive difficulties in formulating language, and in other cases it might be because the client is overwhelmed by their feelings, and in still other cases it may simply be due to the complexity of the events they

2. I am grateful to Ivan Leudar for access to data marked "CBTM".

are reporting. In everyday talk, the listener has a range of practices open to them to prompt the speaker to clarify what he or she is saying. Such prompts encourage the speaker to go on, and to elaborate. What is noticeable in the data here is that the practitioners will, even when there is a manifest obscurity in what their client is saying, forgo such prompts for clarification. The upshot is that the client's tale runs into the sand. Consider what happens below, in Extract 4. The therapist asks the client to explain how he felt (lines 1–2) about an episode which had been established a little before this extract begins. As you will see, the client starts off with an answer to that question, but quickly veers off into a narrative report about the events of a certain day.

In the extract, blank space between brackets identifies talk which is impossible to transcribe, and words in brackets represent a guess at what the client possibly said.

Extract 4. AJ4 min 15.00 "Buzzer"

```
01    T: So how did it make you feel at the time
02       when that happened?
03    C: >I felt a bit, I was in a, I was a bit, (    )<
04       that day.
05    T: Uh huh
06    C: I think she picked the wrong person.
07 →  T: Mm
08    C: Cause the lassie's, the lassie's (too noisy to go
09       wi').
10 →  T: Mm hmm
11    C: Her just keeping the, keeping the buzzer, pressing
12       the buzzers?
13 →  T: Mm hmm
14    C: (      ) (a' the time). But she said it was my
15       close, to Helen, keep back from my door. Stop
16       pressing my buzzer.
17 →  T: Mm
18    C: But I'm not daeing it. But they kept, the close
19       that day.
```

Possibly the client means his report on the events at his home to shed light on his feelings, but what he is saying is very unclear (possibly it involves troublesome neighbours). The doubt that it might not to be about 'feelings' at all seems to induce the therapist to forego any directive prompt that would encourage elaboration. At the arrowed lines, the therapist receives this narrative with the most minimal "continuers" (Schegloff 1982) which signal only that he is attentive, but forgo

clarification of the story, on the basis (we presume) that the story is a distraction from the therapeutic goal of the moment, namely to get the client to articulate his emotional reaction rather than the details of the physical events.

(3) The practitioner echoes part of client's turn as a prelude to topic shift

Topics in conversation are often shifted 'step-wise' (Jefferson 1984) – that is, not by an abrupt change of gear (though that can happen) but by some prefatory work that projects the closure of one topic and the potential to open another. One way of doing the prefatory work that seems apt for the institutions of therapy and supporting people with intellectual impairments is to repeat back to the speaker something they have said, as a form of confirmation or understanding check. This generates the expectation that the client will confirm their 'own words', and allow the practioner a more open field in which to project her or his own turn. In the extract below, from a psychotherapy session, the therapist is in the process of getting the client to list episodes of distress. However, the client takes the opportunity to go beyond mere listing, and begins a narrative, seemingly involving an episode of domestic troubles. Note how the practitioner summarises what the client says as a preface to moving on by 'just thinking about' a related topic.

Extract 5. AJ4 min 9.00 "moonlighting"

```
01    C: Too much in m'mind, it's- today I came
02       happy but there's still inside (yer) hurt.
03    T: Uh huh. Uh huh
04    C: The hurt hat's er-, I mean, (when y'r sayin')
05       something. Because of the carry on with the missus.
06       I was still watching what she, what she done.
07    T: Right
08    C: They were watching us up in the house, got us
09       up in the house. Moonlighting the furniture.
10       See when the kids ( ) back home, (ma home).
11 →  T: Took the kids (out of) the house, back [(t'yer own),
12    C:                                        [Aye. Yeah.
13    T: OK. What about, em, hhh j- just thinking about this,
14       you know, it's great, because the last time, you know,
15       you've a really good memory of what we did the last
16       time.
```

The client is relating a story, which may be over-elaborate for the needs of this stage of the session. The therapist's summary echo and confirmation at line 11

moves the talk away from the vivid detail of the story, and the demands of contiguity (Sacks 1987), and prefaces a move the conversation back onto the business of the session.

(4) The practitioner offers a 'formulation' of client's talk which closes the topic

In the preceding section, we saw how a therapist could 'echo' and clarify the client's actual words. That is a specific variant of a more general practice of proposing to a speaker what is ostensibly a mere summary or natural consequence of what they've just said – what Heritage and Watson call 'gist' and 'upshot' formulations. What gives a formulation extra spin, however, which can be used to bring the talk back 'on-track', is that it deletes a certain part of what the client said, and, in selecting another part, transforms it to some degree (Heritage and Watson 1979).

In this example, the therapist is taking down the client's history in an early session. The objective is to make a record of his episodes of voice-hearing, and specifically their extent (not their content).

Extract 6. CBTM AG/HD session 1 "Nasty voice"

```
01    C: b't it j'st seem to be a nasty voi-I might feel a bit
02       (.)bit better, when soon's=I (.6) er y't- (1.0)
03       >wunnit,wunnit< wite (.) wite- why'it says summi'
04       like er (.3) (.) er (bitch) or (tick=or) summin' like
05       'at >n'ye-< (.4) .h (.) but ee- ee- it does (.) (or
06       dog or whatever) (.) it's very er- it's
07       menacing, you know,
08    T: m::
09    C: doesn't seem to er go away, (.5) ('n)'it's very nasty.
10 → T: so it's not long [sentences then is it. (.) it's [not
11    C:                  [(yeh snog-)                    [no
12 → T: er (.3) it's saying the odd [word and repeatin' it]
```

The client is understandably concerned to get across the subjective emotional tone of the voices he hears, but the therapist has a different objective: to determine the (as it were) objective extent or depth of the hallucination – how long it lasts, how articulate it is, and so on. Hence, rather than orient to the troubling nature of the voice, (it is *nasty* and *very menacing*), the therapist at line 10 formulates the issue as being (merely) one of sentence length: *it's not long sentences then, it's not er it's saying the odd word and repeating it*. This deletes the nastiness of the voice in favour of the diagnostic issue of articulacy. The client at first plays along (*yeh*

repeatin whole sentences) but then he adds more detail (not shown), again of a troubling sort: *hittin someone or whatever or losing me rag* (an idiom for 'losing my temper', in British English). Again the therapist formulates the trouble away: *yeah so you've been doing a lot of writing down*. This allows her to bring the talk back to the current agenda. In the example below, from a different pair of client and therapist, the therapist has the same recourse to a minimising, topic-closing formulation, again formulating a neutral gloss on a highly-charged report:

Extract 7. CBTM SH/JR 07/07/98 min 47 "Rubbing"

```
01    C: I saw the sexual act before really, bc'z- (1.1)
02       once, this bloke, (.3) this bloke came in th-=might
03       have been (h')boyfriend, (.) .h and he just put a
04       hand between her legs and started rubbing, y'know,
05       (.5) an (I=ws) terribly embarrassed, >I s'd<
06       Gra:ce, y'know, (.5) an er (.5) she just
07       looked at me an looked away y'know, an em (.7)
08       as if it didn't matter y'know, (.5) >but I thought
09       that< w'z horrible, really.
10       (.5)
11  → T: some very strange goings-on there really, weren't
12       there.
13       (.8)
14    C: ye:ah.
```

At the point in the session where this exchange takes place, the therapist is trying to get the client to agree to do 'homework' – to practice certain behavioural and cognitive procedures which will combat negative memories. The client nevertheless dwells on a narration of the details of a distressing childhood experience; such troubled announcements provide normally for encouraging news receipts. As we saw in the example of the voice-hearer above, the therapist not only withholds such encouragements but goes further, and offers a neutral formulation of the client's trouble: *some very strange goings-on there really, weren't there* (lines 11–12). The formulation not only deletes the vivid detail of the tale, but – especially with the agreement-projecting tag question, solicits affirmation from the client. Thus an ostensibly simple summary of 'her own words' has been used to bring the topic to a less distressing and more neutral close and allow the therapist to proceed with the task of setting the homework.

(5) The practitioner explicitly orients to the business at hand

We are going up the gradient of what the practitioner can do to pull the client's talk back on track. As we move towards more directive tactics, we see that the practitioner can explicitly orient to either the management of the interview, which we shall see later, or, in the first case we see below, to reintroduce a question that has still not been dealt with satisfactorily.

In Extract 8 immediately below a psychotherapist is in the process of getting the client to say how he felt at certain points during the previous week. The client has nominated an occasion on which he felt angry with his ex-wife, but at line 7 he switches time-frame to the present, and report his *current* feelings. Note how the therapist receives this off-track talk.

Extract 8. AJ4 min 11.30: "Hurts"

```
01   C: And then she phones back, comes later and says,
02      I got your message,= I say, I phoned you three
03      times(  ). How've you no phoned back (  )
04   T: Right
05   C: And (I say ok then).
06      (1.0)
07   C: It still hurts me no seein' Craig.
08   T: Mm hmm. OK. Ab- absolute-=An- and how did you,
09 →    you know, when you spoke to her, how were you when
10 →    you spoke to her?
```

After the client's disclosure of his current feelings, it would have been open to the therapist to enquire further into the client's distress at not seeing his son. Instead, what we see is the therapist respond with a minimal receipt (as in examples seen earlier) and explicitly reissue the question that is pending – how the client actually felt during that episode: *how were you when you spoke to her?*

A further, and still more directive practice is open to a practitioner – an orientation to the management of the talk. By its very nature, the structure of an interaction between client and practitioner is one where there is a more-or-less fixed set of objectives to be got through; and because of the asymmetry in who has rights to move the talk along, it falls to the practitioner to monitor this progress. They can invoke it explicitly, as in this case, which occurs in the early part of the session where a therapist is generating an agenda for the meeting. We join after the client has been talking for some time about her difficulties in getting to sleep:

Extract 9. CBTM: SH and JR Session 1 min 6: "Sleeping"

```
01    C: but I suppose I should get into bed
02       at eleven o'clock, but if I get into bed at
03       eleven o'clock- (.5) I feel like my voice is
04       echoing, you know like when you're talking an'
05       (.3) y'feel like your voice is outside of your
06       head, (.7) it's strange.
07       (.6)
08    C: ern
09       (.5)
10    C: but erm (1.2) .pt if- (.3) (<wha'ma sayin:'>)
11       (   [       )
12    T:     [.hh-
13       (.3)
14 → T: I wonder if you'd mind if I kindov- (.3) just
15 →    stopped you there for a moment, (.) cos we've
16 →    [got quite a lot of things=we were setting an
17    C: [(-   -   -)
18 → T: agenda, (.) .h just to help us structure the
19 →    session a little bit
```

The client has been talking for some time about her difficulties in getting to sleep and at line 10 issues what might be construed as an invitation to the therapist to help her formulate her words and describe her feelings more accurately. But this would be to prolong a troubles-telling in a part of the session devoted to agenda-setting, and the therapist takes the opportunity instead to issue a politely marked request that the client stop there. We are clearly moving up the gradient of direction.

(6) Non-engagement with the client's talk

In the data from interaction s between support staff and adults with intellectual disabilities, but not in the therapy sessions, it was quite common for the practitioner to 'tune out' clients' talk that was considered to be irrelevant or distracting. Even if the client explicitly solicited a response from the staff member (in the form of a question, for example), the staff, on many occasions, did not abide by the expectation to provide the response, and instead pursued a different trajectory (either involving that client, or involving others, or on some other business). Here is a typical example. Staff members Kath and Oonagh are establishing where each of the residents wants to go on holiday. While Oonagh is recording another resident's choice, Alec addresses talk to her, but she does not respond (line 3).

Extract 10. CHW VD17 4:19. Holidays / who's that?

```
01          ((Oonagh is writing))
02   Alec   (to Oonagh) (but y' can't see cars, see cars.)
03   Oona   [((continues writing without looking up))]
04          [                (2.0)                  ]
05   Alec   (to fellow resident Oliver) who's that then
06          (pointing at something in a brochure)
07   Oliver ((gets up and adjusts his clothing, without
08          orienting to Alec))
09   Kath   (to another resident, Dominic) are you happy to
10          with Oliver, Dominic?
11          ((Kath continues to talk with Dom for c. 11 seconds))
12   Dom    nods
13   Kath   good, well done, thumbs up,
14   Alec   (to Kath) who's that one (pointing at something in
15          a brochure)
16   Kath   (not looking at Alec, but possibly at the brochure)
17          oh:kay:
18   Oona   (  ) read the last
19   Kath   well j's read the last one
20   Oona   of the last meetin'
21   Kath   oh:kay: (.5) allright ((looks up addressing the
22          table as awhole)) we'll jus- read what you wanted
23          to do last time.
24   Alec   ((while Kath continues, he leans back in his chair
25          and looks away))
```

After failure to get a staff member to respond to his observation (which is not well formatted), Alec poses a question to a fellow resident, but again is unsuccessful. Then he waits until Kath has finished her questioning of Dominic (signalled by her assessing his responses as 'good well done, thumbs up, line 13), and asks her a direct question (line 14–15). Kath's utterance at this point (lines 16–17) is ambiguous as to its orientation. It may be an acknowledgement of Alec's question (though it is not a reply to it), but it may be a preface for a general announcement of next topic. After a prompt from Oonagh, Kat's full turn at lines 21–23 reveals it, at least retrospectively, to have been this general announcement. So in this brief episode, Alec's efforts to get the talk onto his own track have been ignored by the staff, who pursue the institutional objective in hand.